AUDIT & GOVERNANCE COMMITTEE – 2 JUNE 2021

ANNUAL REPORT OF THE CHIEF INTERNAL AUDITOR

RECOMMENDATION

1. **The committee is RECOMMENDED to consider and endorse this annual report.**

Executive Summary

2. This is the annual report of the Chief Internal Auditor, summarising the outcome of the Internal Audit work in 2020/21, and providing an opinion on the Council's System of Internal Control. The opinion is one of the sources of assurance for the Annual Governance Statement.

3. The basis for the opinion is set out in paragraphs 23 – 36, followed by the overall opinion for 2020/21 which is that there is **satisfactory** assurance regarding Oxfordshire County Council's overall control environment and the arrangements for governance, risk management and control. It is positive to note that the number of audits reporting significant weak internal controls has reduced over the last few years from five in 2018/19, two in 2019/20 and one in 2020/21.

Background

4. The Accounts and Audit Regulations 2015 require the Council to maintain an adequate and effective Internal Audit Service in accordance with proper internal audit practices. The Public Sector Internal Audit Standards 2017 (PSIAS), which sets out proper practice for Internal Audit, requires the Chief Internal Auditor (CIA) to provide an annual report to those charged with governance, which should include an opinion on the overall adequacies and effectiveness of the internal control environment, comprising risk management, control and governance.
5. Oxfordshire County Council's Internal Audit service conforms to the PSIAS 2017.
6. The Accounts and Audit Regulations 2015 require the Annual Governance Statement (AGS) to be published at the same time as the Statement of Accounts is submitted for audit and public inspection. In order for the Annual Governance Statement to be informed by the CIA's annual report on the system of internal control, this CIA annual report has been produced for the May Audit and Governance Committee meeting. This is the full and final CIA annual report.

Responsibilities

7. It is a management responsibility to develop and maintain the internal control framework and to ensure compliance. It is the responsibility of Internal Audit to form an independent opinion on the adequacy of the system of internal control.

8. The role of Internal Audit is to provide management with an objective assessment of whether systems and controls are working properly (financial and non-financial). It is a key part of the Authority's internal control system because it measures and evaluates the adequacy and effectiveness of other controls so that:

   - The Council can establish the extent to which they can rely on the whole system; and,
   - Individual managers can establish how reliable the systems and controls for which they are responsible are.

Internal Control Environment

9. The PSIAS require that the internal audit activity must assist the organisation in maintaining effective controls by evaluating their effectiveness and efficiency and by promoting continuous improvement.

10. The internal audit activity must evaluate the adequacy and effectiveness of controls in responding to risks within the organisation's governance, operations and information systems regarding the:

    - Achievement of the organisation's strategic objectives;
    - Reliability and integrity of financial and operational information;
    - Effectiveness and efficiency of operations and programmes;
    - Safeguarding of assets; and
    - Compliance with laws, regulations, policies, procedures and contracts.

11. In order to form an opinion on the overall adequacy and effectiveness of the control environment the internal audit activity is planned to provide coverage of financial controls, through review of the key financial systems, and internal controls through a range of operational activity both within Directorates and cross cutting, including a review of risk management and governance arrangements. The Chief Internal Auditor's annual statement on the System of Internal Control is considered by the Corporate Governance Assurance Group when preparing the Council's Annual Governance Statement.

The Audit Methodology

12. The Internal Audit Service operates in accordance with the Public Sector Internal Audit Standards (PSIAS). The annual self-assessment against the standards is completed by the Chief Internal Auditor. It is a requirement of the PSIAS for an external assessment of internal audit to be completed at least every five years. This was undertaken by Cipfa in November 2017 and the

results were reported to the Audit & Governance Committee in January 2018. This confirmed that the "service is highly regarded within the Council and provides useful assurance on its underlying systems and processes"

13. The Monitoring Officer conducted a survey of Senior Management on the effectiveness of Internal Audit. The results from this survey were presented to the March 2019 Audit & Governance Committee meeting. The conclusion from the survey was that management find the internal audit service effective in fulfilling its role. The next survey is planned for 2021/22.

14. The Internal Audit Strategy and Annual Plan for 2020/21 was presented to the May 2020 Audit and Governance Committee. The Committee then received quarterly progress reports from the CIA, including summaries of the audit findings and conclusions. The Audit Working Group also routinely received reports from the Chief Internal Auditor, highlighting emerging issues and for monitoring the implementation of management actions arising from internal audit reports.

15. The Internal Audit Plan, which is subject to continuous review, identified the individual audit assignments. The activity was undertaken using a systematic risk-based approach. Terms of reference were prepared that outlined the objectives and scope for each audit. The work was planned and performed so as to obtain all the information and explanations considered necessary to provide sufficient evidence in forming an overall opinion on the adequacy and effectiveness of the internal control framework.

16. Internal Audit reports provide an overall conclusion on the system of internal control using one of the following ratings:

    GREEN There is a strong system of internal control in place and risks are being effectively managed.

    AMBER There is generally a good system of internal control in place and the majority of risks are being effectively managed. However, some action is required to improve controls.

    RED The system of internal control is weak and risks are not being effectively managed. The system is open to the risk of significant error or abuse. Significant action is required to improve controls.

17. In appendix 1 to this report there is a list of all completed audits for the year showing the overall conclusion at the time audit report was issued, and the current status of management actions against each audit, (based on information provided by the responsible officers).

18. To provide quality assurance over the audit output, audit assignments are allocated to staff according to their skills and experience. Each auditor has a designated Audit Manager or Chief Internal Auditor to perform quality reviews at four stages of the audit assignment: the terms of reference, file review, draft report and final report stages.

The Audit Team

19. During 2020/21 the Internal Audit Service was delivered by an in-house team, supported with the specialist area of IT audit. From April 2020 under a joint working arrangement the team also provided the Internal Audit Service to Cherwell District Council. This has enabled us to build a more sustainable team with the skills and capacity resilience to help embrace current and future challenges. The audit management team strongly believe that working as an in-house internal audit function in any organisation drives an increased quality of output, as not only do the in-house team members have a good strategic and operational understanding of the organisation, but also have an ongoing commitment to organisational improvement and adding real value.

20. To be able to provide the joint service across Oxfordshire County Council and Cherwell District Council, additional resources were agreed by CEDR (Chief Executive Direct Reports) for Internal Audit and Counter Fraud. We have undertaken several recruitment campaigns during the year and successfully recruited to Senior Auditor and Assistant Auditor posts. We also now have recruited to the dedicated Counter Fraud posts.

21. Throughout the year the Audit and Governance Committee and the Audit Working Group were kept informed of staffing issues and the impact on the delivery of the Plan.

22. It is a requirement to notify the Audit and Governance Committee of any conflicts of interest that may exist in discharging the internal audit activity. There are none to report for 2020/21.

OPINION ON SYSTEM OF INTERNAL CONTROL

Basis of the Audit Opinion

23. The 2020/21 plan has not been fully completed. There has been some delay at the end of the year with the completion of fieldwork, mainly due to additional work required to certify additional grants received in respect of Covid-19 funding and also extra time required to complete some audit fieldwork and testing remotely. There is one audit (Order of St Johns) that is still at exit meeting/draft report stage, the results of this audit have been included within the annual opinion for 2020/21. The executive summary for this outstanding report will be included within the next Internal Audit quarterly update to the committee.

24. The plan is intended to be dynamic and flexible to change. 22 audits were undertaken. Since the last report of amendments to the plan at the January Audit & Governance Committee meeting, there have been a couple of further amendments, 2 audits have been deferred to the 2021/22 plan (Client Charging and Payments to Providers) and this work has been replaced with 3 additional grants that have required review and certification. These amendments are recorded in appendix 1, with the 2020/21 plan update.

25. The completed internal audit activity and the monitoring of audit actions through the action tracker system enable the Chief Internal Auditor (CIA) to provide an objective assessment of whether systems and controls are working properly. In addition to the completed internal audit work, the CIA also uses evidence from other audit activity, including counter-fraud activity, and attendance on working groups e.g. Corporate Governance Assurance Group.

26. In giving an audit opinion, it should be noted that assurance can never be absolute; however, the scope of the audit activity undertaken by the Internal Audit Service is sufficient for reasonable assurance, to be placed on their work.

27. A summary of the work undertaken during the year, forming the basis of the audit opinion on the control environment, is shown in Appendix 1.

28. Of the 22 audits undertaken for 2020/21, one was graded as RED; SEND. In 2019/20, two audits were graded as Red and in 2018/19 five were graded Red.

29. The overall opinion for each audit, highlighted in Appendix 1, is the opinion at the time the report was issued. The internal audit reports contain management action plans where areas for improvement have been identified, which the Internal Audit Team monitors the implementation of by obtaining positive assurance on the status of the actions from the officers responsible. The current status of those actions is also highlighted in appendix 1, for each audit. Reports on outstanding actions have been routinely reported to Directorate Leadership Teams, CEDR and the Audit Working Group. The Chief Internal Auditor's opinion set out in below takes into account the implementation of management actions.

30. As part of governance arrangements developed when Oxfordshire County Council joined the Hampshire Partnership in July 2015, it was agreed that the Southern Internal Audit Partnership (SIAP) would provide annual assurance to Oxfordshire County Council on the adequacy and effectiveness of the framework of governance, risk management and control from the work carried out by the partnership, via the Integrated Business Centre (IBC). Due to the onboarding of three new partners, since 2019/20 the assurance arrangements were amended. The Hampshire Partnership/IBC commissioned Ernest and Young (EY) to undertake a Service Organisation Controls review under International Standard on Assurance Engagements (ISAE 3402). (This provides a framework for reporting on the design and compliance with control objectives related to financial reporting. In addition to this Partners can separately take a view on any additional risk-based pieces of assurance work that could be commissioned from SIAP covering any core elements of the control environment.

31. The ISAE 3402 report covering both the design and operating effectiveness of the internal control environment for 2020/21 has been shared with the Director of Finance and the Chief Internal Auditor. This report provides assurance on the operation and effectiveness of internal controls across; Purchase to Pay, Order to Cash, Cash & Bank, HR & Payroll and IT General Controls. The report concludes that the controls related to the control objectives were suitably designed and operated effectively, with no exceptions noted.

32. The anti-fraud and corruption strategy remains current and relevant. In 2020/21 the Audit & Governance Committee have been updated on reported instances of potential fraud. Most of these are minor in nature. Work has been undertaken to address the control weaknesses identified in each area identified to reduce the possibility or reoccurrence.

33. Internal Audit continue to manage the National Fraud Initiative data matching exercise which is completed once every two years. Key matches are investigated, and results are reported to the Audit & Governance Committee in the quarterly updates.

34. It should be noted that it is the responsibility of management to operate the system of internal control; not internal audit's responsibility. Furthermore, it is management's responsibility to determine whether to accept and implement recommendations made by internal audit or, alternatively, to recognise and accept risks resulting from not taking action. If the latter option is taken by management, the Chief Internal Auditor would bring this to the attention of the Audit and Governance Committee.

35. The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required.

36. In arriving at our opinion, we have taken into account:

    - The results of all audits undertaken as part of the 2020/21 audit plan;
    - The results of follow up action taken in respect of previous audits;
    - Whether or not any priority 1 actions have not been accepted by management - of which there have been none;

      (Priority 1 = Major issue or exposure to a significant risk that requires immediate action or the attention of Senior Management. Priority 2 = Significant issue that requires prompt action and improvement by the local manager)

    - The effects of any material changes in the Council's objectives or activities;
    - Whether or not any limitations have been placed on the scope of Internal Audit – of which there have been none.
    - Assurance provided by ISAE 3402 report, covering both the design and operating effectiveness of the Hampshire Partnership/IBC internal control environment.
    - Corporate Lead Assurance Statements on the key control processes, that are co-ordinated by the Corporate Governance Assurance Group (of which the Chief Internal Auditor is a member of the group), in preparation of the Annual Governance Statement.

Chief Internal Auditors Annual Opinion

In my opinion, for the 12 months ended 31 March 2021, there is **satisfactory** assurance regarding Oxfordshire County Council's overall control environment and the arrangements for governance, risk management and control.

Where weaknesses have been identified through internal audit review, we have worked with management to agree appropriate corrective action and timescale for improvement.

This opinion will feed into the Annual Governance Statement which will be published alongside the Annual Statement of Accounts.

Oxfordshire County Council's Internal Audit service conforms to the Public Sector Internal Audit Standards (2017)

See Appendix 2 for definitions of overall assurance opinion.

Audits completed since last report to A&G Committee

37. The outcomes of the audits, including a summary of the key findings are reported quarterly to the Audit and Governance Committee. The summaries of the audits completed since the last report (January 2021) are attached as appendix 3;

- IT Asset Management
- IT Web Portals
- Payroll
- Troubled Families – claim 3
- Childrens Education System Implementation
- Covid Expenditure
- Music Service
- Childrens – Management of Placement Vacancies
- Pensions Administration
- Family Solutions Plus
- Risk Management
- AMHP (Adult Mental Health Practitioners)

The following audit is still to be completed and is currently at exit meeting / draft report stage. The outcomes of this audit are included within the annual opinion; the executive summary of the report once finalised, will be presented in the next internal audit quarterly update to committee

- Order of St Johns Contract

Internal Audit Performance

38. The following table shows the performance targets agreed by the Audit and Governance Committee and the actual 2020/21 performance.

39. Performance in achieving the target date for the exit meeting for each assignment has been impacted upon because of Covid-19 pressures. This is something we will continue to focus on and improve. It is pleasing to report that performance for the issue of draft and final reports has improved since last year. We are also pleased to report the significant improvement with implementation of management actions, which normally is reported at between 65-70%, this has increased to a 79% implementation rate and the leadership team (CEDR) are committed to improving this further. Our customer satisfaction questionnaires continue to provide positive feedback.

Measure	**Target**	**Actual Performance 2020/21 – as at 12/05/2021**
Elapsed time between start of the audit (opening meeting) and the Exit Meeting	Target date agreed for each assignment by the Audit Manager, no more than three times the total audit assignment days	50% of the audits met this target. 2019/20 61% 2018/19 69% 2017/18 60%
Elapsed time for completion of the audit work (exit meeting) to issue of draft report	15 Days	85% of the audits met this target. 2019/20 74% 2018/19 82% 2017/18 95%
Elapsed time between issue of draft report and the issue of the final report	15 Days	80% of the audits met this target. 2019/20 74% 2018/19 85% 2017/18 92%
% of Internal Audit planned activity delivered	100% of the audit plan by end of April 2021.	74% of the plan was completed by the end of April 2021 (including grant certification work). 2019/20 70% 2018/19 100% 2017/18 100%

% of agreed management actions implemented within the agreed timescales	90% of agreed management actions implemented	As at 12 May 2021: 569 actions being monitored on the system. • 79% implemented • 13% not yet due • 6% partially implemented • 2% overdue
Customer satisfaction questionnaire (Audit Assignments)	Average score < 2 1 - Good 2 – Satisfactory 3 – Unsatisfactory in some areas 4 – Poor	Average score was 1.06 2019/20 1.17 2018/19 1.07 2017/18 1.03
Directors satisfaction with internal audit work	Satisfactory or above	The review of the effectiveness of internal audit is undertaken by the Monitoring Officer - results of this was reported to the March 2019 Audit & Governance Committee – Satisfactory. Next review planned for 2021.

Sarah Cox, Chief Internal Auditor, May 2021

Background papers: None

Contact Officer: Sarah Cox, Chief Internal Auditor.

APPENDIX 1 - Overall conclusion and management action implementation status of 20/21 audits

Audit	Status	Conclusion	No of Mgmt Actions Agreed	Reported implementation status as at 12/05/2021
Cross Cutting				
Covid-19 funding audit - Test and Trace - Temporary place of rest - School Transport - Early Years	Final Report	Amber	17	2 reported as implemented, 15 not yet due
Communities (now Environment & Place)				
Highways Contract Management	Final Report	Amber	12	9 reported as implemented, 2 being implemented and 1 with no response
Customers & OD (now includes Resources)				
Music Service	Final Report	Amber	39	8 reported as implemented, 31 not yet due
Risk Management	Final Report	Amber	14	14 not yet due
IT				
ICT Incident Management	Final Report	Amber	8	7 reported as implemented, 1 not yet due
ICT Disaster Recovery Planning	Final Report	Amber	11	9 reported as implemented, 2 superseded
ICT Asset Management	Final Report	Amber	10	5 reported as implemented, 5 not yet due

ICT Web Portals	Final Report	Amber	9	5 reported as implemented, 4 not yet due
Finance				
Payroll	Final Report	Amber	11	8 reported as implemented, 3 not yet due
Pensions Administration	Final Report	Green	2	2 not yet due
Childrens				
Management of Placement Vacancies	Final Report	Amber	9	9 not yet due
Family Solutions Plus	Final Report	Green	2	2 not yet due
Troubled Families Claim 1 Claim 2 Claim 3	All three claims – completed and signed off	n/a	0	n/a
Childrens Education System Implementation	Final Report	Amber	15	6 reported as implemented, 8 not yet due and 1 due
Childview System – IT Application	Final Report	Amber	11	8 reported as implemented, 3 due
SEND	Final Report	Red	41	24 reported as implemented, 12 not yet due and 5 being implemented
Carterton Community College	Final Report	Amber	20	17 reported as implemented, 3 being implemented
Adults				
Order of St Johns Contract	Exit meeting / Draft Report	TBC	TBC	TBC

Approved Mental Health Professionals Team	Final Report	Amber	10	3 implemented and 7 not yet due
Grant Certification				
• Better Broadband Programme (2018/19 financial year) – completed June 2020 • Better Broadband Programme (2019/20 financial year) – completed June 2020 • Local Authority Bus Subsidy (Revenue) Grant 2019/20, No 31/3644 – completed September 2020 • Disabled Facilities Capital Grant 2019/20 – completed October 2020 • Local Transport Capital Block Funding (Integrated Transport and Highway Maintenance) Grant 2019/20, No 31/3693 – completed September 2020 • Local Transport Capital Block Funding (National Productivity Investment Fund) Grant 2019/20, No 31/3689 – completed September 2020 • Covid-19 Emergency Active Travel Fund Grant Determination (2020-21): No 31/5099 – completed March 2021 • Additional Dedicated Home to School and College Transport Section 31 Grant S31/5137, S31/5268 and 31/5370 – completed April 2021 • Travel Demand Management 31/5127 – completed May 2021				

Amendments to 2020/21 OCC Internal Audit Plan (since last update to A&G – Jan 2021)

Deferred – Adults – Payments to Providers	Deferred to 21/22 at the request of Assistant Director of Finance and Deputy Director – Adults. The new Social Care Finance and Systems team became operational at the end of November 2020, this included the new Payments and Systems Data Team that saw teams from Finance, Adult Social Care (ASC) and Children, Education & Families (CEF) consolidated into a single service to manage the recording and payments to ASC and CEF providers. Whilst bringing the team together has been positive and has consolidated all the financial activity as intended, this has coincided with a unexpected increase in workload coupled with the transition for the new team being quite difficult. Some of this is related to Covid-19 activity. The consequence is an effect on the overall performance of the team, including some delays in payments to providers. This has been escalated to Senior Management, who as a result have requested the audit is deferred to 2021/22 so the focus of the team can be on the development of an action plan and resource needed, and to ensure the team are able to prioritise dealing with payments and provider queries.	Included within new plan for 2021/22
Deferred – Adults – Client Charging	Deferred to 2021/22 – the audit testing was not completed by the end of April due mainly to additional Covid-19 grant certification work that has had to be undertaken, as a requirement of those individual grant conditions. The audit fieldwork is continuing, and the audit will be finished during May/June.	Included within new plan for 2021/22
Addition – Grant Certification work	3 additional grants required certification: Covid-19 Emergency Active Travel Fund Grant Determination (2020/21): No 31/5099 Additional Dedicated Home to School and College Transport Section 31 Grant S31/5137, S31/5268 and 31/5370 Travel Demand Management 31/5127	Completed as part of 2020/21 plan

APPENDIX 2

Overall annual opinion – definitions based upon framework recommended by Institute of Internal Auditors.

Substantial

There is a sound framework of control operating effectively to mitigate key risks, which is contributing to the achievement of business objectives.

- no individual audit engagement graded as “red” or significant “amber”
- occasional medium risk rated weaknesses identified in individual audit engagements although mainly only low/efficiency weaknesses
- internal audit has confidence in managements attitude to resolving identified issues.

Satisfactory

The control framework is adequate and controls to mitigate key risks are generally operating effectively, although a number of controls need to improve to ensure business objectives are met.

- medium risk rated weaknesses identified in individual audit engagements
- isolated high risk rated weaknesses identified for isolated issues
- no critical risk rated weaknesses were identified
- internal audit is broadly satisfied with management’s approach to resolving identified issues.

Limited

The control framework is not operating effectively to mitigate key risks. A number of key controls are absent or are not being applied to meet business objectives.

- significant number of medium and/or critical risk rated weaknesses identified in individual audit engagements
- isolated critical and/or high risk rated weaknesses identified that are not systemic
- internal audit has concerns about managements approach to resolving identified issues.

No Assurance

A control framework is not in place to mitigate key risks. The organisation is exposed to abuse, significant error or loss and/or misappropriation. Objectives are unlikely to be met.

- serious systemic control weaknesses identified through aggregation of individual audit engagements
- significant number of critical and/or high risk rated weaknesses identified for isolated issues
- internal audit has serious concerns about managements approach to resolving identified issues.

APPENDIX 3

Summary of Completed 2020/21 Audits since last reported to the Audit & Governance Committee - January 2021.

IT Asset Management 2020/21

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Corporate Policy	R	0	2
Procurement	A	1	2
Inventory Management	A	0	1
Hardware Disposal	A	0	4
		1	9

Opinion: Amber		
Total: 10	Priority 1 = 1	Priority 2 = 9
Current Status:		
Implemented	5	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	5	

Formally documented corporate policies are not in place for all areas of IT asset management, such as procurement and inventory management. The ICT Disposal of Equipment Policy is dated April 2018 and missed its annual review in 2019. The gaps in formal policies means there is a risk that there are no agreed standards for managing IT assets, including defined roles and responsibilities.

All new IT equipment should be procured centrally through IT Services. There are isolated cases where service areas procure their own IT equipment, but they have to contact IT Services to have it connected to the network. The new starter process is used to identify

and request new IT equipment and is also used to request access to corporate business systems, such as LAS (Adult Social Care) and LCS (Children's Social Care). However, our testing identified that such requests do not have to be approved at a management level and hence there is a risk of unauthorised access being granted to systems that hold sensitive personal data. This could result in a data breach and financial penalties under the Data Protection Act 2018.

New IT equipment was previously procured under a framework agreement, which has now expired, and tendering for a new supplier has been delayed because of the Covid-19 pandemic. Since the lockdown period began in March 2020, there has been a significant national increase in the demand for portable equipment such as laptops. The existing framework supplier was unable to handle requests for the required number of new computers and hence IT Services used a different supplier during this period. Quotes were always requested and reviewed prior to any order being placed but comparative quotes were not always obtained, especially for laptop computers, as the priority was being able to source the volume of equipment needed. As demand levels and market conditions return to normal, it is important that comparative quotes are obtained until a new framework supplier is selected to ensure value for money is achieved.

New computers once delivered are not added to stock records until they are unpacked. Under normal conditions such equipment is held in a secure area but the recent volume of equipment has meant that an office area has also been used for storage. New equipment should be added to stock records on delivery to ensure it can be tracked and that any lost or stolen items can be identified.

There is an IT asset inventory on the new service desk system, which takes regular automated feeds from other systems to maintain details. Access to the inventory was confirmed to be appropriately restricted. However, we have identified a number of weaknesses with the management of the inventory, including timelessness of adding new equipment, recording of disposals, consistency in recording details and data from old legacy spreadsheets not being fully migrated to the new system. There is also no formal process for identifying and tracking computers that have not logged onto the network for a period of time to determine if they are still being used or whether they can be re-deployed.

There is a formal contract with the supplier of IT hardware disposal services, who was selected in March 2019, and there have been two disposals of IT equipment in 2020, one in February and another in July. We found that there are no documented procedures for the disposal of IT assets so processes along with roles and responsibilities are not clearly defined. In addition, the way in which equipment is listed on the different set of disposal documents makes it difficult to confirm that all assets are collected and processed for disposal by the supplier.

ICT Web Portals 2020/21

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Logical Security	G	0	0
Access Rights	G	0	0
Audit Trails	G	0	0
Data Processing	A	0	2
Server Security	A	0	4
Legislative Compliance	R	0	3
		0	9

Opinion: Amber		
Total: 9	Priority 1 = 0	Priority 2 = 9
Current Status:		
Implemented	5	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	4	

There are a number of web portals within Adult's and Children's services which can be accessed by carers and providers for submitting online forms, mileage claims, invoices and sending messages. New users can self-registrate for a portal account, a process which involves having to supply an email address which is verified during the registration process. The exception to this is the children's provider portal where there is no self-registration and all accounts are set-up by the finance team on the ContrOCC system. All self-registered portal accounts are password protected and there is a two-step login process which involves entering a password and a token code that is sent to the designated email address. There is no account lockout feature on portals to lock user accounts after a specified number of failed logins, however, after each failed login there is an increased time delay before further attempts can be made, thus mitigating some of the risk.

New portal accounts are not granted any access permissions by default. All new accounts are manually verified to a carer record in the back-end application e.g. LCS or LAS, after which the user has access to send messages and submit online forms that have been published to them.

There is an audit trail available on portals which show the date/time of a user's last login and also provides the date/time of any form they submit or message they send. Details on failed portal logins are stored in the database and can be queried by LiquidLogic but the information is not available to IT Services. This is a result of the design of the system and leaves an inherent risk that failed logins cannot be reviewed and monitored.

Forms that are submitted via the portal go into a designated "task tray" in the back-end application where they are picked up, linked to a carer record and processed. A review of a sample of forms confirmed that, wherever possible, they include completeness and validation checks through the use of mandatory fields, drop-down lists and calendar functions. No validation issues were also identified with the submission of mileage claims and invoices on the children's provider portal. New forms are specified by service areas and built by IT Services and we are recommending the process around this be formally documented in regard to authorisation etc, specifically in terms of any personal data that is collected on a form. Forms are tested in a User Acceptance Testing (UAT) environment before being approved for use but we found that some UAT environments do not reflect live environments and hence testing my not identify all issues and errors.

A review of the servers running the Children's and Families web portal and the Citizen web portal found that they are on supported operating systems, fully patched, have up-to-date anti-virus software and are logically separated in the De-Militarised Zone (DMZ) of the network. The number of local accounts on both servers is limited and local administrator account passwords are managed using LAPS (Local Administrator Password Solution) in accordance with good practice. However, a review of the local administrator group on both servers identified accounts which need to be removed. We performed a vulnerability scan on the two servers and identified a risk around the use of weak encryption ciphers which should be addressed to prevent any personal data being compromised. The servers were built by LiquidLogic and it is not clear if they have been security hardened to reduce the attack vectors; this should be confirmed. There is a comprehensive level of auditing on the web portal servers, which log all critical activity, but we found that the event logs overwrite themselves after a very short period of time (under 10hrs) and hence log data may not be available to help identify or investigate a security incident or data breach.

The compliance of web portals with legislative requirements is a key risk area. Web portals have not been assessed for accessibility by disabled users, do not comply with privacy legislation in regard to the use of cookies and also with GDPR requirements in relation to the processing of personal data.

OCC Payroll 2020/21

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Policies & Procedures	G	0	0
B: Starters & Leavers	A	1	4
C: Variations, Adjustments, Deductions & Additions to Pay	A	0	6
D: Management Information	G	0	0
		1	10

Opinion: Amber		
Total: 11	Priority 1 = 1	Priority 2 = 10
Current Status:		
Implemented	8	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	3	

Policies & Procedures – Testing undertaken as part of this audit has confirmed that there is relevant guidance in place for staff on key payroll processes. Testing confirmed that this guidance has been updated with changes made in April 2020 such as codes for additions to pay and holiday pay entitlement. In addition to intranet guidance on the OCC intranet and IBC help pages, there is also additional sources of help available via the IBC helpdesk and web chat function and a dedicated HR advice email address.

Starters & Leavers – New starter sample testing identified an overpayment to a new starter, this instance was also part of as sample tested by External Audit. This error was not identified until queried during audit testing and was found to be due to a keying error when the employees start date was entered on IBC. Extended sample testing and analysis by Internal Audit found no other instances where start dates had been recorded incorrectly or where new starters had been overpaid. As a result of this case additional information has been provided by Finance to Cost Centre Managers on their responsibilities in monitoring and reviewing staffing costs. It has also been noted by

Internal Audit that there is a need for some additional exception reporting by HR going forward.

New starter testing noted cases (6/10) where staff contracts were not issued prior to or on the employees start date as is required by the Good Work Plan issued by Department for Business, Energy and Industrial Strategy in December 2018. Whilst there is one case where it appears that the contract is still outstanding for a role that started in May 2020, other delays ranged from 1 day to 3 months.

The saving of employee contracts to individual Electronic Personnel Files (EPFs) has not been completed in all cases sampled. 6/20 contracts tested were not saved to the relevant EPF. This testing has also identified a lack of clarity over roles and responsibilities and process for processing of new starters and the issue of contracts for some Fire & Rescue Staff hires. Testing identified 3 cases where it appears that no contract of employment has been issued.

Issues were again noted (as per previous 2018/19 payroll audit) with timeliness of completion of leaver actions resulting in overpayments despite clear guidance, news items and reminders for managers being issued during the year. An example was noted where a recalculation of a leaver overpayment which should have been completed by the IBC, had been overlooked.

Variations, Adjustments, Deductions & Additions to Pay – From sample testing on variations to pay, a number of examples were identified where supporting documentation was not uploaded to the employee's EPF. This was noted as being a particular issue in documenting agreed honorarium payments. For the 3 cases tested, no honorarium form could be provided. It has been difficult to evidence that honorarium timescales (which have exceeded the specified 6 month timescale for the payment of honorariums) and values were appropriate. Although the honorarium process is clearly documented, there are no system controls to prevent managers from entering honorariums for their staff via IBC without following the required process or that highlight where the correct process has not been followed. A webform for actioning the payment of an honorarium with inbuilt approval workflows (development agreed as a management action during the previous audit in 2018/19) is in the process of being tested prior to roll out, this will make it easier for HR to monitor compliance with the required process.

Testing also identified instances where temporary contracts are continuing past their agreed end date without being ended or extended by managers, this includes two cases where temporary contracts ended several years ago (one in 2016 and the other in 2018) where employees are still in post and being paid and a further case where a permanent contract should have been issued following the expiry of the temporary contract in 2016.

Management Information – Regular detailed management information is produced for HRBP's on key payroll areas (for example overtime payments, honorariums and

casual claims). It was also confirmed that there is a clear process in place for discussion of payroll issues between OCC and the IBC with appropriate escalation routes in place.

Follow up - 1 management action agreed as part of the 2018/19 Payroll audit relating to the development of a webform for the actioning of honorarium payments is in the process of being implemented. It has been reported that the form has been developed and is now in the final stages of testing prior to roll out. The 2018/19 management action will be superseded with a revised action agreed within this report.

This audit provides assurance over the controls implemented and operated by OCC. Separate assurance over IBC operated controls and processes is received annually from Hampshire / IBC.

Troubled Families Claim 3 2020/21

The March 2021 claim consisted of **78 families for Significant & Sustained Progress (SSP)**, however due to the high number of families already claimed for this year, the maximum that could be claimed for March in was 70. This brings the total for the year to the MHCLG's target of 477 families. The MHCLG has previously confirmed that remaining families (8) can be submitted at the start of April when the window reopens, forming part of next year's claim.

The audit of the previous claim (October 2020) identified no issues or management actions, owing to the previous improvements to the process for identifying duplicate claims and updates to the Think Family Outcome Plan. All previous actions from previous audits have been implemented.

The audit checked a sample of 15% of the total SSP claim (12 families) to ensure that they met the relevant criteria for payment and had not been duplicated in the current or previous claims. Their initial eligibility criteria for inclusion in the Programme were also checked.

Overall Conclusion

The audit noted the improvements in the internal processes for data checking and validation made following previous claims have remained effective. Testing for duplicates found no families that have previously been claimed for, and no issues were identified with the eligibility or sustained progress of the families sampled. Testing also confirmed the effective implementation of new processes to evidence sustained progress against the attendance criterion, given home schooling as a result of Covid-19.

Due to satisfactory responses having been received for all queries raised by Internal Audit, this claim can be signed off for submission.

As such, no audit findings or management actions are required.

Childrens Education System Implementation 2020-21

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Project Structure	**A**	**0**	**7**
Project Reporting	**A**	**0**	**4**
Project Planning	**A**	**0**	**1**
Project Costs	**A**	**1**	**1**
Supplier Management	**G**	**0**	**0**
Lessons Learned	**A**	**0**	**1**
		1	**14**

Opinion: Amber		
Total: 15	Priority 1 = 1	Priority 2 = 14
Current Status:		
Implemented	6	
Due not yet actioned	1	
Partially complete	0	
Not yet Due	8	

In 2018, Children's started a project to replace the Capita ONE education case management system. Following a formal procurement exercise, Liquidlogic were selected as the preferred supplier and a contract was signed in December 2020. The Liquidlogic EYES (Early Years and Education System) solution is being implemented alongside their finance case management solution, LIFT (Liquidlogic Integrated Finance Technology).

A Project Initiation Document (PID) has been produced and is going through an approval process. A review of the draft PID found that it is comprehensive and covers key areas such as business case, project objectives, scope and project governance. The PID includes the anticipated benefits of the project but there are no measurements against these and hence it will be difficult to confirm if they have been delivered at the end of the project. A project structure has been put in place to manage the project, which includes a Project Board and a Project Team. The Project Board has been in situ since 2018 and has a documented

terms of reference, however, we found that it needs updating and does not fully define the responsibilities of each Board member. Clarity is needed over who is performing the key Project Sponsor role and the reporting line of the Project Manager also needs to be reviewed as it does not currently report into Children's or IT Services. We also found that some of the roles on the Project Team have yet to be filled.

Project risks and issues are recorded on a RAID log which is maintained by the Project Manager and was found to be up to date. The exception noted on the RAID log is that issues are not RAG rated and hence it is difficult to distinguish critical ones from those that are less important. A Highlight Report is produced for the monthly Project Board and includes an overall project RAG status and details other key activity for the period. The report has a section on risks and issues but this is used by the Project Manger to highlight any specific risks and issues that they want to bring to the Board's attention and does not routinely include the biggest risks on the RAID log. The Project Manager has attended the IT Digital & Customer Programme Board to give an update on the project. However, the Programme Board do not monitor the project as it is not categorised as a full IT Project. Whilst there are members of IT Services on the Project Board and Project Team, the IT Digital & Customer Programme Board should have greater visibility of the project to ensure any technical resources and support are available when required. A Communication Plan for the project has also not been documented as the communications lead role has yet to be filled.

A project plan has been developed and is maintained by the Project Manager. There is a separate high-level implementation plan within the supplier contract, which is still being finalised and agreed. The project plan should be updated to reflect the agreed contract implementation plan to ensure project tasks are completed in accordance with contractual milestones. The staff resources required by the project from both children's and ICT has been identified and the project budget includes the backfill of key roles.

A project budget has been agreed and a breakdown of costs is available although there is no formally defined responsibility for managing and monitoring the budget or regular reporting on project finances to the Project Board. This could lead to the project budget not being effectively monitored at Board level. Supplier payments are linked to milestones and the first two invoices submitted for payment have been verified by the Project Manager and approved by the Project Sponsor.

There is a formal contract with the supplier which was signed on 21 December 2020. Contract management and monitoring, in terms of deliverables, is performed by the Project Manager and the Procurement Lead, who is a member of the Project Board.

There is a comprehensive Lessons Learnt Log from the children's social care system implementation and some of those lessons have benefited the early stages of the project, including writing the tender specification and agreeing to deploy standard system configurations instead of bespoke ones. Beyond this there is no evidence that the lessons learnt have been shared with all project stakeholders or of any Project Board ownership that the lessons are applied to the remainder of the project.

Covid Payments and Expenditure 2020/21 – Summary Report

Opinion: Amber		
Total: 17	Priority 1 = 5	Priority 2 = 12
Current Status:		
Implemented	2	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	15	

Introduction

As part of the revised Internal Audit plan for 2020/21, CEDR requested an audit of a sample of Covid-related payments and expenditure, to provide assurance over the accuracy and integrity of spend. Risks in this area were recognised due to the urgency and volume of spend, as well as the short timescale for setting up payment arrangements. Nationally, there have been inherent fraud risks associated with Covid-related payments, support and relief.

A sample of 4 Covid payment areas were selected for testing:

1) Test and Trace Service Support Grant
2) Temporary Place of Rest (TPOR) at Upper Heyford.
3) Early Years and Childcare Covid grants
4) 85% Transport Covid payments

Separate management letters have been issued containing the detailed findings and agreed actions for each of the 4 areas. This letter summarises the findings across all areas reviewed.

Background / Scope of work

At the outset of the pandemic and first lockdown in March 2020, a number of projects and grant payments were set up to respond to the pandemic and to support key Council suppliers. At this time, OCC stood up their Gold Command structure to direct and oversee the Council's pandemic response strategy, with Silver and Bronze Command Cell groups overseeing the various operational elements (Gold, Silver and Bronze respectively being the Strategic, Tactical and Operational command structure for managing a crisis situation in OCC).

This audit selected the 4 areas to review based upon an assessment of materiality, risk and coverage across Directorates. This section explains the background and scope of work covered for each of the 4 areas:

1) **Test & Trace Support Service Grant:**

This was a government grant of £2.9m to support local authorities in their Test & Trace activities. OCC has only partially spent this grant funding so a full audit has not yet been completed. The government require Chief Internal Auditor sign-off on this funding so once expenditure has been completed a full audit will be undertaken and reported on. To date, the governance structure and key processes have been reviewed, with some recommended actions implemented as a result.

2) **Temporary Place of Rest (TPOR) at Upper Heyford:**

In response to the expected rise in excess deaths, regional TPORs were commissioned in March 2020 and the site at Upper Heyford was agreed by the Strategic Commissioning Group for the Thames Valley, in line with the Excess Deaths Plan.

The speed in which this facility was transformed from aircraft hangars to TPORs is noted, as the site became operational in 10 days. In total, 3 Hangars were transformed into TPORs for a period of up to 6 months (April – September 2020) at a cost of £2.5m.

The scope of the audit included the governance arrangements, decision-making and oversight of the set-up and running of the TPOR between March-September 2020. The audit reviewed how suppliers were selected and managed, as well as the financial and asset management controls in place.

3) **Early Years and Childcare Covid grant funding**

CEDR agreed to several tranches of Early Years and Childcare grant funding from March 2020 to support Early Years and Childcare providers within Oxfordshire, totalling £1.3m. The funding aim was to minimise the risk of permanent closure and severe financial hardship for providers.

The Early Years team set up the grant funding arrangements, informed providers eligible to apply, and assessed applications for funding approval or decline. The audit reviewed a sample of 20 applications to check the application and decision-making process.

4) **85% Transport Covid payments**

In the first Covid lockdown a large number of home to school transport routes were suspended, with only a small number continuing to run. Government advice regarding payments to suppliers was set out in Procurement Policy Note 02/20 (“PPN02/20”) and was followed in regard to paying these transport providers.

CEDR agreed that where contracted routes continued to run 100% of the contracted daily rate would be paid and where contracted routes were, by agreement with the

Council, no longer running (Suspended Routes) CEDR agreed to pay 85% of the contracted daily rate. This arrangement was initially due to last until 30th June 2020 but was extended beyond this date due to the continued closure of schools. Approval was sought via the Finance and the Procurement Cells prior to CEDR approval.

A total of £1.3m was paid to providers for the 85% payments between April – June 2020, which is the period covered by this audit. The audit reviewed a sample of 10 providers that were paid the 85% support payments to verify the award and payment process followed. This included checking that signed agreements were in place, audit returns had been submitted, verified drivers were paid, confirmation that the routes on the audit return were suspended routes and eligible for the claim and that contract rates and invoices were correct.

Overall Conclusion

Based on the sample of the 4 areas reviewed, our overall conclusion is AMBER. The Council has demonstrated good strategic governance over these Covid-19 funding arrangements. For the grants, the funds have been disbursed promptly and following a defined application and checking process. For the government-funded grants reviewed, the grant conditions have been complied with.

Where issues were identified during the audits, these frequently stemmed from the fact that processes had to be set up in a short period of time, with the onus on a quick operational turnaround and disbursing payments to support providers promptly. The operational context at the time was fast-changing and Officers were challenged with keeping abreast of new government guidance and schemes.

In the case of the TPOR, issues were identified which stemmed from inadequate contract management and procurement practices (which are being addressed via the wider provision cycle improvement work). The audit identified queries related to the probity of payments to suppliers (which have resulted in a robust response by the organisation to investigate and follow up). Weaknesses were also identified relating to asset control. In the case of the Early Years payments and the 85% Transport payments, the issues identified were in relation to a lack of robustness of checks of the applications / return forms / invoices which resulted in some errors in payment values (which are being reviewed) and assessment processes that could have been more transparent (such as having clearer evidence-based financial information to support the grant awards).

Music Service 2020/21

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Governance and Risk Management	A	0	5
B: Financial Management	R	1	7
C: Purchasing and Procurement	A	0	4
D: Asset management	A	0	1
E: Contract management and grant compliance	A	0	3
F: Administration and systems	A	0	4
G: Safeguarding	A	0	6
H: Health and Safety	A	0	8
		1	38

Opinion: Amber		
Total: 39	Priority 1 = 1	Priority 2 = 38
Current Status:		
Implemented	8	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	31	

The audit noted a number of areas where improvements in the control environment at the Music Service have been made over the last year since the previous audit, such as more embedded safeguarding practices, more regular SMT meetings and improved budget monitoring oversight. The audit noted a Directorate leadership drive to address the issues within the Music Service. As such, interim leadership arrangements have been put in place in recent months to address current staffing gaps in leadership positions. Additional support is being provided by the Cultural Services Improvement Team to document the administrative and process weaknesses previously identified, with a view to establishing clearer, more efficient processes. Once the impact of these initiatives has taken effect and the management action plan fully implemented, a more positive assurance opinion should be visible.

At the current time, there are still a number of areas of weakness in the internal control environment at the Music Service. The context of the past year has to be factored into this assessment; with the challenges presented by the Covid-19 lockdowns as well as senior leadership changes resulting in a lack of stability for the Service – as detailed in the following sections.

A: Governance and Risk Management

Significant issues were identified in the 2019/20 audit and a management action plan was subsequently agreed. Although the absence of a Head of Music Service for over a year has resulted in a lack of management capacity to help drive through the necessary changes and improvements. More recently, there has also been leadership change with the Assistant Director overseeing the Music Service leaving. This has resulted in senior leadership capacity issues for the Music Service, although interim leadership arrangements have been put in place (a longer-term solution is still required). The impact of Covid-19 restrictions has hampered the ability of the Service to make changes over the past year, as it has had to operate reactively to respond to the pandemic situation, thereby reducing their capacity to act proactively to address the list of issues that require improvement.

Oversight for Music Service activity and performance is provided by the Directorate leadership as well as Oxfordshire Music Education Partnership (OMEP). The previous audit highlighted some issues regarding a lack of clarity over OMEP's role and oversight – the new Terms of Reference for OMEP have clarified this and have recently been accepted by the OMEP Board. From this point on once the new ToR are embedded, OMEP's role in governance and oversight should be strengthened.

Assurance over the performance, quality and compliance of the Service is provided by a Performance Dashboard with KPI's covering service targets and financial information. However, there are gaps in this assurance mechanism, and the action from the previous audit to implement a Quality Assurance Framework to cover all areas of risk (e.g. timely submission of grant returns, safeguarding compliance, financial control) hasn't been implemented.

The audit noted a co-operative Senior Management Team (SMT), with regular meetings held, which were minuted and appropriately covered all areas, including Finance (which previously had been absent). There was evidence of far more communication and engagement with staff, who are kept up-to-date with information from SMT on a regular basis. Some clarity over the division of responsibilities between SMT members was still required.

There is now greater clarity on the appraisal process for staff, however monitoring that monthly 1:1s are taking place in accordance with the 12:3:2 Council corporate policy requires improvement. The HR structure in IBC is still out of date, resulting in incorrect management lines on the system.

B: Financial management

The audit noted that there are weaknesses within financial management of the Music Service. The previous audit highlighted inadequate budget monitoring practices, which resulted in an unexpected year-end overspend. Whilst budget monitoring has improved, the financial position of the Music Service is still a challenge. In 2019/20 there was a loss of £189k and in 2020/21 a loss of £807K (to be funded from reserve funds, government grants, and corporate balances). There are several causes of the significant loss position, including:

- Covid-19 lockdown impacting upon the business and a reduction in income;
- Structural changes required to the Music Service have not taken place partly due to Covid-19 and partly due to the leadership gaps noted above;
- The cost/benefit analyses of each strand of the Music Service business has recently been completed, so did not impact the 2020/21 budget but is forecast to reduce the deficit in 2021/22 to £47k.

Although a deficit budget for 2021/22 has been signed off, a sustainable business model and structure needs to be implemented to ensure the Music Service does not continue in deficit beyond this.

Some further issues noted in the previous audit that were still evident in the current audit included:

- A requirement to put in place clear procedures for the Finance team to follow
- Non-compliance with (and a lack of understanding of) corporate Finance procedures
- At the time of the audit the 'Special Account' still had not been completely reconciled and closed down (although at the time of audit reporting this had been closed)

Additional areas of testing from the current audit has also identified the following issues (some of which have been long-standing):

- Non-compliance with finance timescales across all areas tested – such as invoice payments, debt recovery and debt write-off
- Non-compliance with Debt Recovery procedures
- Bad debtors not flagged on the Speed Admin system so potentially further lessons could be booked and further debt accrued
- Purchase Orders raised retrospectively in 59% of cases, resulting in late invoice payments (the average number of days to pay from the invoice date was 110 days)

C: Purchasing and procurement

At the time of the audit, purchasing card transactions had not been reviewed due to the absence of a Head of Music Service, however a substitute has now been recorded on the system who will review and authorise the transactions.

The Scheme of Delegation held on the OCC intranet is not up to date and includes a member of staff who left in August 2019 and only one member of the current SMT who would not routinely be carrying out purchasing or procurement activity. The current Business Manager (the cost centre manager) is not included on the documented scheme of delegation.

Only one substantial procurement had been undertaken by the Service in recent years. The audit noted that the contract value was over £25k over 3 years, however a competitive procurement process was not followed (e.g. obtaining 3 quotes) as only the annual value of the contract was considered.

D: Asset management

From the limited remote testing that the audit could perform under Covid restrictions, issues with the timeliness of and responsibility for updating loaned items on Speed Admin were noted. In 3 of the 10 items sample tested issues were noted, as they (a MacBook, an iPad and an instrument) had been returned to the Service but not updated on the system or the location was unknown (the instrument).

E: Contract Management & Grant Compliance

The Music Service does not have many contracts or areas of high contractual spend. The largest by value is a software system and the audit noted the Service did not have a copy of the contract (though a copy was obtained during the audit).

The timeliness of submission of ACE returns had improved following the previous audit. However, the audit trail for compiling the data was inadequate.

F: Administration & Systems

The Administration team do not have adequate documented procedures (this was noted in the previous audit also) and in particular there is no staff User Guide for Admin software system, resulting in inefficiencies and a greater risk of errors. However, the Cultural Services Improvement Team are currently undertaking a review with the Team to map the processes and utilise the Admin system capabilities better.

From audit testing on the system, errors were noted with the adjustments to accounts which were necessary due to lessons not being set up correctly and then not cancelled correctly resulting in duplicate charges being made. In one case, the lesson charges cancelled were incorrect resulting in an under payment.

G: Safeguarding

The audit noted progress had been made with improving the safeguarding controls, including a more robust system to record and monitor DBS checks and contact made with the OCC LADO (Local Authority Designated Officer). However, there were some areas that require further work:

- The LADO inspection noted in the previous audit actions is still required and has not taken place due to restrictions under Covid-19.
- During the audit it was brought to our attention that the DfE Prohibition from Teaching checks had not been carried out as part of pre-employment checks. These checks have now been included in a new recruitment procedure currently in draft form.
- Safeguarding does not feature in the KPI's and without the development of the more holistic Quality Assurance Framework there is a gap in assurance.

H: Health & Safety

Whilst some progress has been made with the Health & Safety actions agreed in the last audit and subsequent subject-specific H&S reviews, this is an area where implementation has been particularly impacted by the Covid-19 lockdown restrictions. Some actions, such as staff training and updating some policies and procedures have been completed, however the majority remain outstanding, as follows:

- There are a number of outstanding actions from the Fire Risk assessment conducted in May 2019 and followed up in March 2020 and September 2020. The majority of these relate to FM and are reported to have been escalated to the Hard Services Lead for FM yet are outstanding.
- The housekeeping exercise identified for the Music Service to complete is ongoing and has been hampered by Covid-19 restrictions on office attendance.
- There are a number of areas in the Site Logbook and Fire Safety Logbook that have not been completed.

Covid-19 risk assessments are in place that cover the areas of work currently being undertaken due to Covid restrictions and have been reviewed by the Corporate H&S Team. Going forwards, as the restrictions ease, the Music Service will need to ensure that the business as usual risk assessments and H&S tasks are completed.

Follow Up

This audit report incorporates all actions not implemented from the previous audit report and new actions from this report.

The previous audit resulted in an agreed management action plan with 56 actions to address the weaknesses identified. This audit has confirmed that 22 are fully implemented, 22 are partially implemented, 5 are not yet implemented. A further 4 actions were not tested during this audit, and 3 were no longer relevant due to the closure of a business.

Childrens – Management of Placement Vacancies 2020/21

Overall conclusion on the system of internal control being maintained	**A**

RISK AREAS	**AREA CONCLUSION**	**No of Priority 1 Management Actions**	**No of Priority 2 Management Actions**
A: Identification of Requirements	**G**	**0**	**0**
B: Sourcing of Placements	**A**	**0**	**0**
C: Placement Management	**R**	**0**	**3**
D: Contract Management & Quality Assurance	**R**	**0**	**4**
E: Management Information & Reporting	**A**	**0**	**2**
		0	**9**

Opinion: Amber		
Total: 9	Priority 1 = 0	Priority 2 = 9
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	9	

Overall, the audit identified strong arrangements in place to monitor and forecast the number and types of placements required and noted progress being made against previously identified gaps in provision. Sample testing of placements confirmed sourcing attempts are being made in line with established priorities and placements are being authorised appropriately.

Areas where the need for improvements were identified include the completion of provider accreditation checks, contract management of spot contract arrangements, and processes for the management of safeguarding / quality concerns relating to providers. These areas of weaknesses had been previously identified but were to be addressed following the implementation of the HESC (Health, Education & Social Care) model and associated restructure. It is acknowledged that the implementation of the new model and structure is still in a process of transition, with new roles and responsibilities and management of ongoing vacancies.

Timeliness of completion and the quality of IPAs (Individual Placement Agreements) was found to be an area requiring improvement, with delays in both issuing and finalisation of the agreements.

Identification of Requirements

The Council's Commissioning Strategy for Children We Care For Placements aims to ensure that there are sufficient placements to meet the needs of children in care, allowing the Council to meet its sufficiency duty under the Children Act 1989 while driving a consistent an focused approach to sufficiency, cost effectiveness, market development, and good outcomes for children and young people. The current strategy, which covers 2020-2025, was updated following an externally commissioned needs analysis exercise of all children in care, and market analysis of available placements, both nationally and to the Council. The strategy notes the key gaps in provision identified as part of this analysis, and, combined with other existing service planning and transformation work, sets out the Council's strategic priorities and commissioning intentions for children's placements.

The audit noted good progress against a number of these intentions, with action plan updates being regularly provided to the Placement Sufficiency and Third-Party Savings Board, along with progress on individual projects which have been set up to address specific areas and challenges. Review of the Board papers also confirmed appropriate involvement of all relevant teams, to enable a joined-up approach and information sharing across services, as well as informing future commissioning activity and strategies.

Sourcing of Placements

Review of a sample of 25 placements made in the past 12 months and covering different types of contracts and placements confirmed sourcing attempts are being made in line with established priorities and Entry to Care (or Head of Service) authorisation. For those sampled, internal provisions were attempted first, then block contracts, followed by frameworks, and finally spot placements, and where providers had declined referrals it was found to be a result of child matching or ability to meet the needs of the placement.

While good examples of cross organisational working were noted throughout the audit, with Placement Officers and Social Workers working together to identify and secure appropriate placements, two exceptions were noted in which Social Care Teams progressed sourcing without informing the Placement Officers. Three exceptions also were noted in which referrals did not contain an appropriate level of detail to allow placements to be sourced effectively.

The audit noted weaknesses in the provider accreditation process, which is required when placements are made with providers who are new to the Council or have not been used recently. Of the 25 placements reviewed, five required an accreditation check, and while LCS records indicated this had been requested, the team within Quality & Contracts responsible for carrying out the checks were only able to confirm the outcome of one, having no record of the other four having been requested. A further case was identified in which

an accreditation check took six weeks, by which point the placement had been made, broken down, and a new placement was being sourced.

Placement Management

Audit testing highlighted ongoing weaknesses with the timeliness of completing IPAs, which are required for all external placements and act as the contract with the provider, setting out the child/young person's outcomes and any information around cost and services provided. Analysis of an IPA tracking spreadsheet maintained by the team responsible for completing and finalising IPAs found that of the 178 external placements recorded since January 2020, 110 had finalised IPAs (62%). These were completed, on average, 78 days after the placement start date.

Of the remaining 68, the majority (74%) are awaiting the provider's signature, having been sent up to 11 months ago. Analysis of the delays found no single root cause however; outstanding IPAs covered all contract types and delays had occurred at all stages of the process, from receiving outcomes from Social Workers to receiving signed copies from providers.

The quality of information held in IPAs was also found to be an area of weaknesses. Of the ten IPAs reviewed, four did not contain a breakdown of the costs or what had been commissioned as part of the placement (e.g. therapy, 2:1 care) and seven did not contain information around the child's education. The level of detail recorded against placement outcomes widely varied, with some clearly articulating how success against the outcome would be measured and expected timescales for this, and others consisting of single sentences. The expected placement duration had not been completed in the majority of cases, and neither had confirmation that relevant documents had been shared.

Audit testing confirmed Child We Care For Reviews had been carried out within appropriate timescales, although there is currently no requirement for the IPA to be reviewed as part of the child/young person's care planning, or to confirm one is in place. This was reportedly due in part to the quality of information included in IPAs, however, means while the child's Care Plan and Placement Plan is routinely reviewed, there is no assurance provided that what has been commissioned is being received.

Funding Authorisation Forms had been completed with appropriate sign off for all placements sampled. However, while eight required the placement costs to be reviewed after a determined period, with a view to decreasing the level of support required and therefore cost, or returning to Entry to Care to authorise continued cost, reviews could not be evidenced in three cases, with costs continuing beyond the agreed timescales without further authorisation.

Contract Management and Quality Assurance

The audit noted an inconsistent approach to contract management depending on the type of contract the placement is made under. Effective contract management could be demonstrated for the residential block contracts and the residential and Independent Fostering Agency (IFA) South Central Frameworks. It is acknowledged there is currently no permanent, dedicated resource for the management of spot contracts, which continue to

make up a large proportion of placements made. For these spot contracts, there is therefore no monitoring of contractor performance, ongoing due diligence to provide assurance over key areas such as supplier resilience, and health & safety, or oversight to ensure value for money and competitive rates are achieved.

Weaknesses and inconsistencies were identified in the management of provider safeguarding and quality concerns, with no established process to ensure issues are reported appropriately, shared with the necessary teams, or investigated and followed up consistently.

It was reported under the 2019/20 Placement Decisions Audit that responsibilities for these areas would be defined under the transformation work and the new HESC model. The Commissioning Strategy also contains an intention for "all placements to receive appropriate oversight, quality outcomes and safeguarding through a single common process". These arrangements have not yet been fully assigned under the new model, although a project has now been initiated with a view to implement a quality management framework to monitor and assure provisions and identify a more sustainable and robust way to manage contracts.

With regard to the Cross Regional Block Contract, a consortium of Local Authorities each with a contracted number of beds, it was not possible to ascertain who within the Council authorises beds being used by other consortium members, which can be done depending on demand, placement matching, and vacancies. Issues were also noted with payments and charging for the contract. As the lead commissioner of the contract, the Council is responsible for carrying out recharges for the 'bought' and 'sold' beds. This was carried out at year-end, however a review of the spreadsheet used to calculate the charges and payments identified a number of errors, resulting in the other Local Authorities being undercharged and incurring financial loss to the Council.

Management Information & Reporting

The audit noted the developments and improvements made to the monthly occupancy reports reviewed by the Placement Sufficiency and Third-Party Savings Board. These allow effective oversight and scrutiny of placements and vacancies for internal residential homes, internal foster carers, block residential contracts, and Young People Support Accommodation placements, although it was noted no data is currently provided on framework or spot placements. As noted above, positive progress is being made towards the Council's commissioning intentions to be able to source appropriate, local provision, however the availability of accurate and up to date management information on where children and young people are being placed, and the associated costs from taking this approach, is key, so that appropriate commissioning decisions can be made and progress measured.

There is currently no management information or monitoring around the completion of IPAs, an area in which the audit has found significant delays in completion of the agreements, and numerous placements where agreements are not yet in place.

Pensions Administration 2020/21

Overall conclusion on the system of internal control being maintained	G

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Regulatory Framework	G	0	0
Scheme Member Lifecycle	G	0	1
Scheme Employers	G	0	0
Debtor Management	A	0	1
		0	2

Opinion: Green		
Total: 2	Priority 1 = 0	Priority 2 = 2
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	2	

Oxfordshire County Council is the Administering Authority in the Local Government Pension Scheme Regulations, with approximately 190 Employers within the Pension Fund. The audit noted good progress against a number of areas the Pensions Service had been involved in during the 2019/20 Pensions Administration Audit. This includes the Guaranteed Minimum Pension (GMP) reconciliation with HMRC, which is now complete. At the time of the previous audit, the outcome of the Government losing its appeal on the McCloud judgment on discrimination (a national issue) was awaited. The Government announced its response in February 2021, with resulting changes requiring new legislation. This will provide a detailed explanation of individual member's legal entitlement, facilitating the Pensions Team in managing these changes. Although initially delayed, the transfer of Employers to from the MARS system to the I-connect system is now almost complete, aiming to improve efficiencies in terms of data collection and checking, and implementation of the Administration to Pay process has also now commenced.

Regulatory Framework

The team issued Annual Benefit Statements for the 2020/2021 Financial Year within the regulatory deadline, issuing 99.59% of active scheme members and 99.3% of deferred scheme members statements.

The team is currently implementing the Administration to Pay process. This project was originally due to be completed in December 2018 but was pushed back for further software development. Implementation started in February 2021, which is being phased into operation and is expected to be fully implemented by January 2022. The system aims to increase pensions administration processes' efficiency by automating the flow of information from the pensions administration part of Altair to the pensions payroll part of the system.

Scheme Member Lifecycle

Following weaknesses identified in this area during previous audits, payroll processes were re-designed in order to ensure sufficient segregation of duties. Audit testing found that reports showing tasks completed by individuals with access to both the Administration and Payroll functions on Altair to ensure the effectiveness of the segregation of duties were not being run on a regular basis. Over the past twelve months, seven of the monthly reports were carried out retrospectively (up to five months after the payroll) and there were four months where no report had been completed.

Although some delays in completion of scheme member lifecycle tasks were noted from sample testing completed during the audit, these delays were found to be due to external factors. Reported performance against the established Service Level Agreements (SLAs) was found to be strong across the year. Performance is monitored and reviewed on a monthly basis within the team and reported on a quarterly basis to the Pensions Fund Committee.

Scheme Employers

The implementation of the I-connect system, which replaces the MARS data return process and enables employers to upload data directly into Altair has experienced delays against the initial August 2020 implementation date, due to Covid-19 and pressure on the service. Transfer of employers from MARS to I-connect has been phased, with 16 Employers left to transfer at the time of the audit. It is anticipated this will be completed with the last two largest employers by June 2021.

Debtor Management

Further progress is required in developing debtor management and debt recovery processes. The management action agreed within the 2019/20 audit remains outstanding. While there have been a number of discussions around processes over the year, recruitment to the post responsible for debt monitoring and recovery was unsuccessful and there remains no process for the monitoring, follow up or active debt recovery. Current debt at the time of the audit is understood to be just over £136k, which includes 91% of the overdue invoices reported in the 2019/20 Pensions Administration Audit Report (totalling £78k), as no active recovery has been taking place.

It is acknowledged that overpayments identified in the Biennial NFI (National Fraud Initiative) exercise continue to be addressed by one of the Team Leaders, although two historical cases remain outstanding and require further progress in the recovery of the outstanding debt.

Family Solutions Plus 2020/21

Overall conclusion on the system of internal control being maintained	G

Opinion: Green		
Total: 2	Priority 1 = 0	Priority 2 = 2
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	2	

Introduction

The Family Solutions Plus (FSP) model was implemented within the Children's Directorate in November 2020. This transformational project involved implementation of a new practice model of intervention across Oxfordshire to tackle the main causes of parental and family breakdown. The project itself closed at the end of December 2020, following the sign off of the Project Close Request report by DLT. The report highlights the achievement of project objectives and key deliverables with the few remaining outstanding items allocated to specific officers.

The FSP Partnership Board has continued to meet following the closedown, with a reviewed and updated version of the Terms of Reference to reflect the project having moved the model into practice and the project formally ending.

Performance information and reporting has been and is continuing to be developed to enable the Directorate to monitor changes in performance and the realisation of the anticipated benefits of the new model.

This audit focussed on how key components of the FSP model have been implemented to provide assurance over the likelihood of realisation of key benefits and efficiencies and also reviewed the developing mechanisms for performance monitoring and reporting from team level upwards.

An audit of the FSP project was also completed in 2019/20 and focussed on project governance. The overall conclusion was Green. There were 4 management actions agreed as a result of the audit, all have been reported as fully implemented.

Overall Conclusion

Our overall conclusion is **Green**. The implementation of the model appears to have been well managed with management focussed and positive about the new model and what it will enable in terms of better outcomes for families. It is recognised that the FSP Project, planned prior to the pandemic, was implemented during COVID, and during a period of remote working arrangements.

All key components of the new model reviewed at an overview level appear to be in place. Multi-disciplinary teams are now established. Although there have been some recruitment and retention issues resulting in a higher than anticipated need for agency staff, there is an action plan in place to resolve this over the 2021/22 financial year. The Workbook has been rolled out with detailed training and guidance developed in house and rolled out to FSP teams. Motivational Interviewing is also now established, with training rolled out. Whilst there is a need to obtain some assurance on completion of training (in terms of Motivational Interviewing and the training provided on the model and the workbook) to ensure that all relevant staff have completed it, high take up has been reported with MI courses fully booked to late summer. It has been reported that group supervision is taking place, it is planned that this will be reviewed in more detail as part of the 2021/22 FSP audit. It is also positive to note that there is work ongoing to monitor and act on lessons learnt by Hertfordshire from their experiences of implementing the model.

Governance arrangements have been updated following completion of the project with the FSP Partnership Board split into a Steering Group focussed on operational issues and the Board focussed at a more strategic level.

The service has also made good progress in terms of performance monitoring and reporting with key streams being clarified in terms of where and how the anticipated benefits of the new model can be measured and reported on. Whilst it is still early days in being able to see evidence of benefits being realised, there are positive early indications as reported to Children's DLT and CEDR in April 2021.

Performance is being measured via three different frameworks. There is an FSP Evaluation Framework, led by Oxford University in conjunction with OCC which will look at the impact of the new model on families over time, a Benefits Realisation framework which will look to provide evidence that the model is delivering the anticipated savings, with reporting back to CEDR and an internal performance framework which will focus on performance at operational level and provide performance information which will support the Benefits Realisation framework

reporting. This will be monitored via monthly DLT reporting. The internal performance framework went live in April 2021.

Looking forward, options for the development of a more integrated method of performance reporting are being investigated and discussed. It is hoped that it will be possible to introduce an intranet-based performance dashboard which users at operational, tactical and strategic levels of the service can drill down into as required. Discussions are taking place with ICT and the corporate performance team over the technologies available.

Risk Management 2020/21

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Policies, Procedures & Framework	G	0	2
B: Roles & Responsibilities	A	0	2
C: Embedding & Implementation	A	0	4
D: Reporting & Oversight	A	0	2
E: Training & Awareness	A	0	4
		0	14

Opinion: Amber		
Total:14	Priority 1 = 0	Priority 2 = 14
Current Status:		
Implemented	0	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	14	

It is noted that there have been a number of improvements in the corporate risk management approach since the start of 2020. The leadership level risk management process is now well established and embedded with regular review and discussion of leadership level risks and risk scoring at CEDR as well as discussion and consideration of new risks. There is also now regular and routine reporting to members on leadership level risks via inclusion in the public facing Business Management & Monitoring reports.

There is a Risk and Opportunities Management Strategy in place approved by CEDR, considered by AWG and approved by Cabinet in 2019. This has recently been reviewed and updated and the revised version is now in the process of being approved. Intranet guidance is still to be reviewed and updated, although it is noted that what is there is already comprehensive in terms of the risk management process from risk identification through to review of risks. There is still a need to ensure that it is in line with the revised strategy, once approved, and ensure contact details and responsibilities are updated. This has been identified within the Risk Development Plan and is work in progress.

The Risk Development Plan also identifies a number of other required improvements to effectively embed risk management across the Council. Whilst some of the original target dates have had to be moved, primarily due to the events of the last year, the audit noted that progress is being made with making the required improvements. Going forward the Corporate Lead for Risk Management will need the support and engagement of the Directorates to make the required improvements at operational level.

At directorate / operational level it was positive to note that all directorates are using the standard risk register template and recommended approach as per the intranet guidance, however there are areas where risk management practices need to be more formally established and embedded, particularly in relation to DLT level oversight and challenge / review of operational risk registers.

Roles in relation to operational risk management which will act as a liaison with the corporate team are in the process of being defined and confirmed. The corporate team do not currently have any involvement or oversight of directorate level risk management processes and it is acknowledged that until the directorate role has been clearly defined and representatives appointed, there is a need for some additional input from the corporate team to provide assurance over how risk management processes are working and identify areas where more targeted support may be required.

With the exception of Adults, who have regular DLT sessions where operational risk management is discussed and reviewed, DLT level oversight of operational level risk registers is not currently routine or systematic. For the newly formed CODR and CDAI directorates this is because their risk management processes are still being developed, within Children's risk management has been considered in a different way via weekly COVID dashboard reporting and discussions. In Environment & Place they have identified improvements which they are in the process of addressing.

We noted good evidence at directorate / senior management level in terms of their understanding of the risk escalation process. We note that the Risk Development Plan has identified the need for further improvements to the guidance, specifically thresholds for

escalation, to ensure that officers at all levels are confident in how this process works. Another area where clarification is required is on the management of joint risks which could be risks which are leadership and operational risks or that may affect more than one directorate or service area. Some clarity is required on the process for managing these risks so that duplication is avoided but risks are still managed appropriately, and responsibilities are clear.

Training for staff and members is in the process of being developed. This is an acknowledged area for improvement within the Risk Development Plan and is currently work in progress. It is planned that some basic training will be delivered at the start of the summer, alongside completion of a training needs assessment and commissioning of some external training which will be able to pick up on any needs identified from the training needs analysis.

AMHP (Adult Mental Health Practitioners) 2020/21

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Policies and Procedures	A*	0	2
B: Operational Processes	A	0	5
C: Management Information	A	0	2
D: HR	G	0	1
E: Finance	G	0	0
F: Data Access and Security	G	0	0
	Total	0	10

** The amber conclusion also includes the finding reported under the HR section regarding HR policies and procedures*

Opinion: Amber		
Total:10	Priority 1 = 0	Priority 2 = 10
Current Status:		
Implemented	3	
Due not yet actioned	0	
Partially complete	0	
Not yet Due	7	

The AMHPS team have made a number of improvements to team processes since the Team Manager was appointed in early 2020. Team guidance has been reviewed and refreshed, the recording of patient referrals and assessments has been moved over to LAS (as of the end of September 2020) and management reporting is now being generated from LAS as well (starting in January 2021). A case audit process has also been introduced in order to identify strengths and areas for improvement within the team. Whilst it is acknowledged that there are still some areas that require further development and improvement, these have been identified by team management and they have plans in place to address these.

Policies and Procedures – There is detailed team guidance in place covering the referral and assessment process. Whilst there were a couple of areas where it was noted that additions needed to be made, it was observed that management are keen to improve and make changes where necessary. There were examples noted where internal guidance was held in different shared folders and one example of an out of date policy being on file, this is acknowledged by the service with a tidy up of filing planned.

Operational Processes – The team have now moved over to recording on LAS. This is a positive step in being able to standardise processes and enable more automated management information and performance reporting. Some inconsistencies in the use of LAS were noted. Sample testing noted examples where referrals and assessments had not been recorded on LAS, where cases had been recorded on manual forms instead (held on the shared drive and then uploaded to LAS), and cases where it had not been possible to locate referral documentation. It was reported that, around the time of the move to LAS, there was a need to have a manual system to fall back on. There were some examples reported where individual staff were unable to access LAS for recording and where system crashes meant that LAS could not be used for recording, however these issues are all now resolved. There were some inconsistencies noted in recording, some of which has an impact on the accuracy of management information produced. Delays were identified in the completion of assessment reports. The areas for improvement had all been identified by the service who are in the process of putting in measures to address them.

Management Information – As a consequence of the inconsistencies in recording, the accuracy of some of the management information being produced from LAS for Performance DLT meetings in relation to AMHPS Team activity has been impacted. It is positive to note that it has been reported by the Operations Manager that the discrepancies between the information coming from LAS and actual performance have reduced

significantly since the start of the year, indicating increased consistency in the use of LAS since audit testing was completed.

Review of supervision recording noted that the records being maintained for oversight of the supervision process across the team are out of date with none of the sessions sampled as part of the audit recorded on the monitoring spreadsheet.

The case audit process, recently introduced by the AMHP Team Manager, was noted as effectively identifying areas where improvements were required for follow up with individual team members as part of their supervision sessions. However, the frequency and coverage of the case audit process across the AMHPS team was found to be sporadic. To ensure that compliance with the OCC Supervision Policy for Adult Social Care Operational Staff can be demonstrated, it has been agreed that the process will be formalised with case audits taking place at the frequency and coverage required by the policy with clear summary records being maintained to provide assurance that this is taking place. It is acknowledged that cases are also reviewed in detail as part of routine supervision sessions.

Human Resources – Due to the way in which the AMHPS team operates, there are circumstances specific to the team where different pay enhancements and arrangements have been agreed. Whilst it was possible to satisfactorily resolve all audit queries arising as part of our sample testing, it was found that current allowances and agreements can be complicated and confusing with the potential for staff to be unaware of what they are and are not entitled to claim.

Follow up – of the 6 management actions agreed as part of the previous AMHPS audit in 2017/18, all have been reported as implemented. Testing completed as part of this audit has confirmed that 5 actions have been fully and effectively implemented. 1 was not tested as part of this audit.